

Case Number:	CM13-0064689		
Date Assigned:	01/15/2014	Date of Injury:	10/07/2011
Decision Date:	05/23/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 29 year old female who was injured on 10/07/2011 while working as a property manager. One of the tenants killed herself in front of her. She has been having a hard time dealing with the incident even though it occurred almost 2-1/2 years ago. She continues to have severe anxiety and panic attacks, and she gets nightmares and flashbacks of the incident. Psychiatric note dated 01/10/2014 indicated the patient was in for a follow-up office visit. She was not doing very well. She was very nervous, anxious, and irritable. She felt a tremendous amount of guilt about this woman who killed herself in front of her. The patient was instructed to continue her medication, increase the dose of Klonopin 1 mg on a p.r.n. basis 3-4 times a day for anxiety and panic attacks. Her Fanapt was discontinued; Cymbalta dose may need to be increased to 120 mg a day. She needed ongoing psychiatric care and treatment to alleviate the effects of industrial injury. Psychiatric note dated 12/13/2013 stated the patient was in a post-traumatic stress disorder cognitive supportive psychotherapy group. She was very active in relating her emotional status and the insight she had gained from her psychotherapy and from her experience thus far at the day treatment program. She was continuing to gain insight and appeared more stable. She denied suicidal ideations, intent or plan. She claimed that the requested day treatment program additional visits had not been authorized thus far. Authorization for this program had yet been approved.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**URGENT 15 ADDITIONAL DAYS PARTIAL HOSPITALIZATION PROGRAM
SESSIONS: Upheld**

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN PROGRAMS, PAGES 30-33, AND FUNCTIONAL RESTORATION PROGRAM, PAGE 49.

Decision rationale: The medical records do not document how many of these sessions the patient has completed to date. According to the Behavioral Health evaluation dated 11/19/2013, the patient presented with report of her psychological issues affecting her behavior and her family. The report indicated the patient was admitted to a partial hospitalization program with an estimated stay of 2-3 weeks. The patient's strengths were willingness to seek treatment, compliance with medication, and good family support. Her liabilities were suboptimal response to medication. The patient would have to meet the criteria for discharge, which were a decrease in symptoms of PTSD and stabilization of her mood by medications. There lacks clear demonstration of sustained gains and improvement with treatment. According to the Psychiatric note dated 12/13/2010, the patient was very active in relating her emotional status and the insight she had gained from her psychotherapy and from her experience thus far at the day treatment program. She was continuing to gain insight and appeared more stable. She denied suicidal ideations, intent or plan. When re-evaluated on 01/10/2014, the PR-2 indicated the patient was in for a follow-up office visit, and that she was not doing very well. She was very nervous, anxious, and irritable. She felt a tremendous amount of guilt about this woman who killed herself in front of her. The patient was instructed to continue her medication, increase the dose of Klonopin 1 mg on a p.r.n. basis 3-4 times a day for anxiety and panic attacks. Her Fanapt was discontinued; Cymbalta dose may need to be increased to 120 mg a day. The medical records document that adjustments had been made to the patient's medication regimen. It would be prudent to evaluate the patient's response to the medication updates, prior to considering additional treatment interventions. Furthermore, there lacks documentation establishing this patient has utilized and applied the information and skills she should have learned within the program. Medical necessity is not established.